APPENDIX A

United States District Court
Eastern District of Missouri
Eastern Division

St. Louis University, a Missouri Not for Profit Corporation, Plaintiff, vs. Blue Cross Hospital Service, Inc. of St. Louis, et al., Defendants.	No. 73 C 638 (4).

MEMORANDUM

(Filed February 18, 1975)

This action for review of an administrative decision limiting provider reimbursement under the Medicare Act is before the Court upon the motions of the defendants to dismiss and upon all parties' cross-motions for summary judgment.

Plaintiff St. Louis University, through its hospitals, agreed on June 26, 1966, with the defendant Secretary of Health, Education and Welfare ("Secretary") to provide medical services to individuals under Parts A and B of the Health Insurance for the Aged Act, Pub. Law 89-97, 42 U.S.C. § 1395 *et seq.*, as amended ("Medicare Act"), Title XVIII of the Social Security Act.

Pursuant to 42 U.S.C. § 1395 h (1965), defendant Blue Cross Association ("BCA") contracted with the Secretary to serve as a fiscal intermediary in the administration of the Part A Medi-

care program. The intermediary determines the amount of the payments due to providers from the Secretary for Medicare services. The intermediary also makes the actual reimbursement to the providers, may be required to provide consultative services to providers regarding the maintenance of fiscal records, and is to serve as a channel of communication between providers and the Secretary. 42 U.S.C. § 1395 h(a).

BCA subcontracted its duties as a Medicare intermediary in the St. Louis, Missouri, area to defendant Blue Cross Hospital Service, Inc. of St. Louis, doing business as Blue Cross Plan of St. Louis ("Plan"). BCA and its staff work closely with the employees of the Plan and BCA is dependent upon the Plan to carry out BCA's duties as Part A fiscal intermediary.

Pursuant to 42 U.S.C. § 1395 u (1965), General American Life Insurance Company ("General American") agreed with the Secretary to serve as a carrier (with duties similar to those of a Part A fiscal intermediary) in the administration of Part B of the Medicare program.

Although plaintiff may have elected to deal directly with the Secretary in its capacity as provider, it nominated BCA and the Plan to provide intermediary services under Part A, and General American as its Part B carrier.

In 1969 a dispute arose between plaintiff and the Plan over the amount of Part B reimbursement due plaintiff for services rendered by physicians employed on salary by plaintiff; General American had previously reviewed plaintiff's reimbursement claim and approved it. The Plan determined that plaintiff had been overpaid $89,380.00 for the fiscal years ending August 31, 1966, 1967, and 1968, and thereafter proceeded to deduct certain amounts from plaintiff's Part A reimbursement. In reaching this decision the Plan sought advice from BCA on the merits of plaintiff's reimbursement claim. BCA responded with advice contrary to plaintiff's position.

Plaintiff appealed the Plan's decision to the BCA Provider Appeals Committee. This Committee was established by BCA, pursuant to its contract with the Secretary, to resolve provider complaints after a hearing. The Appeals Procedure, under which the Committee acted, provided that the decision of the Committee would be final. The Committee is composed of five members, three of whom are representatives of BCA appointed by the president of BCA; the other two members are chosen by the BCA president from persons nominated by national provider associations also selected by the president of BCA. A quorum of three members is required to conduct a hearing; one of the three must be a BCA vice-president who acts as hearing chairman. Both the provider and the Plan have an opportunity to present evidence, to cross-examine witnesses, and to dispute evidence offered. A stenographic record is kept.

On May 10, 1972, a hearing by the Committee on plaintiff's appeal from the Plan's reimbursement determination was held. On August 16, 1972, the Committee upheld the Plan. Plaintiff commenced this action thereafter.

In their brief filed January 18, 1974, defendants "suggest that this decision [of the BCA Appeals Committee] represents the final, non-reviewable determination of the Secretary . . .".

Defendants' alternative motions to dismiss and for summary judgment are premised upon the grounds that the Court lacks subject matter jurisdiction and that plaintiff failed to state a claim upon which relief can be granted. Fed. R. Civ. Pro. 12(b)(1), (b)(6).

SUBJECT MATTER JURISDICTION

Plaintiff posits alternative statutory grounds for jurisdiction: 42 U.S.C. § 405(g) (Title II of the Social Security Act), 5 U.S.C. § 702 (Administrative Procedure Act), and 28 U.S.C. § 1331 (federal question). Plaintiff alleges, and it plainly appears from

the record, that the amount in controversy exceeds $10,000.00, exclusive of interest and costs.

Plaintiff's claims are three. In Count I plaintiff alleges that the merits of defendants' decision which resulted in the reimbursement limitation is contrary to the provisions of the Medicare Act and the regulations promulgated thereunder, and is "arbitrary, wrongful and discriminatory". To the extent the regulations were correctly interpreted, plaintiff claims they are contrary to the provisions of the Medicare Act and invalid. In Count I plaintiff prays for declaratory relief and for an order directing defendants to properly reimburse plaintiff.

In Count II plaintiff attacks the composition of the BCA Appeals Committee. Plaintiff claims that the review by the Committee, a majority of whom were BCA personnel, did not constitute a fair and impartial review and was a denial of due process of law. Plaintiff further claims that, to the extent that the Appeals Procedure is a delegation by the Secretary of the right to review the decision of the Plan and to determine issues, the delegation is unlawful and denies plaintiff its due process right to impartial administrative review. In Count II plaintiff prays for remand to the Secretary for proper review.

In Count III plaintiff alleges that claims similar to plaintiff's have been allowed, when those claimants utilized a certain bookkeeping method acceptable to the Plan. Plaintiff claims this is unfair, arbitrary and denies plaintiff equal rights and protection of the law; plaintiff prays for relief similar to that sought in Count I.

Defendants assert that this is an action to which the United States has not consented and, therefore, the action is barred by sovereign immunity. The doctrine of sovereign immunity has been severely criticized,[1] but its vitality is unquestionable. *See*

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[1] *See* K. Davis, Administrative Law Treatise, Ch. 27 (1958); Cramton, Nonstatutory Review of Administrative Action, 68 Michigan Law Review 387 (1969-1970).

Gnotta v. United States, 415 F.2d 1271 (8th Cir. 1969); *e.g.*, *Twin Cities Chippewa Tribal Council v. The Minnesota Chippewa Tribe*, 370 F.2d 529 (8th Cir. 1967). It is relevant as a defense to an action, such as this, where the judgment of the Court would "interfere with the public administration" or would "expend itself on the public treasury". *Dugan v. Rank*, 372 U.S. 609, *at* 620 (1963); *e.g.*, *Pine View Gardens, Inc. v. Mutual of Omaha Insurance Company*, 485 F.2d 1073 (D.C. Cir. 1973).

Contrary to plaintiff's argument, neither 28 U.S.C. § 1331 nor the Administrative Procedure Act operates to waive sovereign immunity, *Twin Cities Chippewa Tribal Council, supra, at* 532; nor does the Administrative Procedure Act confer subject matter jurisdiction upon this Court. *Id.*; *see also, Opelika Nursing Home, Inc. v. Richardson*. 356 F.Supp. 1338, 1341 (M.D. Ala. 1973), *aff'd sub nom. Johnson's Professional Nursing Home v. Weinberger*, 490 F.2d 841 (5th Cir. 1974).

Exceptions to the defense of sovereign immunity exist where the subject governmental action is committed without statutory powers or if within those powers, the powers or their exercise are constitutionally void. *Larson v. Domestic & Foreign Corporation*, 337 U.S. 682, 702 (1949); *Malone v. Bowdoin*, 369 U.S. 643, 647 (1962); *Dugan v. Rank*, 372 U.S. 609, 621-622 (1963); *e.g.*, *Gardner v. Harris*, 391 F.2d 885, 888 (5th Cir. 1968). It is not disputed by plaintiff that the Medicare Act empowers the Secretary and the intermediaries to reduce provider reimbursement. *See* 42 U.S.C. § 1395 g. Therefore, the Court concludes that plaintiff's Count II claim alone, raising a constitutional challenge to the BCA hearing process, can survive the defense of sovereign immunity.[2] Jurisdiction to deter-

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[2] Section 405(g), Title 42 U.S.C., does not provide for judicial review of a Medicare reimbursement determination. Schroeder Nursing Care, Inc. v. Mutual of Omaha Insurance Company, 311 F. Supp. 405, 408 (E.D. Wis. 1970). It is not one of the Title II sections incorporated by reference into Title XVIII of the Social Security Act. See, 42 U.S.C. § 1395 ii.

mine the Count II claim exists as granted by 28 U.S.C. § 1331. *Temple University v. The Associated Hospital Service of Philadelphia*, 361 F. Supp. 263, *at* 267 (E.D. Pa. 1973); *cf., Wilson Clinic & Hospital, Inc. v. Blue Cross of South Carolina*, 494 F.2d 50 (4th Cir. 1970); *Coral Gables Convalescent Home v. Richardson*, 340 F.Supp. 646 (S.D. Fla. 1972).

Defendants further argue that 42 U.S.C. § 405(h)[3] precludes this entire action, since that section contains no provision for judicial review of reimbursable cost determinations. This argument must be denied. The Court is persuaded that § 405(h) forbids judicial review of administrative decisions only where the claimant seeks to bypass review procedures provided by the Medicare Act. *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663, 666 (2nd Cir. 1973). As in *Temple University, supra*, when plaintiff's claim arose, the Medicare Act provided no express procedure for review or appeal of a provider-intermediary dispute of this nature.[4] Section 1395 h(a) of Title 42 (1965) provided only that an intermediary's determination of the amount of payments to be paid providers should be "subject to such review by the Secretary as may be provided for by the agreement" between the Secretary and the intermediary.

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[3] Section 405(h) was incorporated into the Medicare Act by 42 U.S.C. § 1395 ii and provides as follows:

> The findings and decision of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decisions of the Secretary shall be reviewed by any person, tribunal or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 [including present § 1331] of Title 28 to recover on any claim arising under this subchapter.

[4] The 1972 Medicare amendments, Pub. L. 92-603, established a five-member Provider Reimbursement Review Board appointed by the Secretary to determine provider appeals from final intermediary determinations. 42 U.S.C. § 1395 oo. These amendments further provided for judicial review of Board decisions. *Id.* This appeal and review procedure applies only to providers' cost reports for accounting periods ending on or after June 30, 1973. Pub. L. 92-603, § 243(c).

Therefore, the application of § 405(h) to prevent plaintiff from bypassing available review procedures is irrelevant here where plaintiff admittedly did exhaust all available administrative review.

The Court concludes that defendants' motion to dismiss Counts I and III must be sustained, but denied as to Count II.

Count II

The record before the Court shows clearly, without any genuine issue of material fact, that the BCA Appeals Procedure, providing for review of the subject Plan-St. Louis University dispute by the BCA Provider Appeals Committee, violated due process by reason of the BCA affiliation of a majority of the Board members. I find the teaching of *Goldberg v. Kelly*, 397 U.S. 254 (1970), that an impartial decision maker is essential, applicable to plaintiff's due process claim:

> We agree with the District Court that prior involvement in some aspects of a case will not necessarily bar a welfare official from acting as a decision maker. *He should not, however, have participated in making the determination under review.* (emphasis added). 397 U.S. *at* 271.

Three of the five Board members who conducted the subject hearing, Chairman Green, Hankle, and Moeller, were BCA employees. BCA had advised the Plan in 1969 on the merits of plaintiff's position and was supportive of the Plan's ultimate decision. Furthermore, BCA was co-contractor with the Plan in providing the intermediary services to plaintiff and the Secretary. The conclusion is inescapable that plaintiff was not afforded a hearing before an impartial decision maker.

The fact that the vote of the Board was unanimous gives defendants faint support. The actual consideration and factors

discussed by the members when they deliberated in closed session can only be speculated upon. It is enough to see the overt relationships between the Plan and BCA, and their relationship to the merits of the dispute being considered, to know that plaintiff was not afforded due process.

In fashioning a remedy, the Court is mindful that both the Medicare Act, 42 U.S.C. § 1395 h(a) (1965), and the constraints of due process require that the Secretary review the record of any hearing afforded plaintiff. *Cf., Appalachian Power Co. v. Environmental Protection Agency*, 477 F.2d 492, 504, n.33 (4th Cir. 1973). The present record is devoid of any such meaningful review by the Secretary that was made in conjunction with the reimbursement limitation and not made in conjunction with the defense of this action.

The Court will remand the plaintiff's appeal from the subject Plan decision to the Secretary for a *de novo* evidentiary hearing before a tribunal that does not contain employees of BCA.

John F. Nangle
United States District Judge

Dated: February 18, 1975

APPENDIX B

United States Court of Appeals
For the Eighth Circuit

No. 75-1274

No. 75-1293

St. Louis University, etc.,
Appellant-Appellee,
v.
Blue Cross Hospital Service, etc., et al.,
Appellees-Appellants.

Appeal from the United States District Court for the Eastern District of Missouri.

Submitted: January 12, 1976.

Filed: April 12, 1976.

Before Gibson, Chief Judge; Clark, Associate Justice, Retired;* and Bright, Circuit Judge.

Bright, Circuit Judge.

These appeals follow an action brought by St. Louis University challenging certain HEW-mandated procedures and seeking to recover alleged overcharges repaid to HEW by appellant

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* Associate Justice Tom C. Clark, Retired, United States Sureme Court, sitting by designation.

pursuant to an administrative determination by appellees Blue Cross Hospital Service, Inc. of St. Louis and the Blue Cross Association. The dispute arises from services rendered and payments made during appellant's fiscal year ending August 31, 1966, pursuant to the Medicare provisions of the Social Security Act of 1965.[1] In response to cross motions for summary judgment, District Judge John F. Nangle, on February 18, 1975, dismissed counts I and III of the University's complaint but granted relief on count II. The University appealed the dismissal of counts I and III and defendants cross-appealed the judgment on count II.[2]

I. **Background.**

In order to place this case in the proper perspective, the internal organization of St. Louis University must be examined. St. Louis University, as part of its program in the school of medicine, owns and operates a general hospital known as Firmin Desloge Hospital and a psychiatric unit known as the Wohl Institute. These two institutions are known as the St. Louis University Hospitals. The hospitals serve as a teaching and training facility for the school of medicine and provide medical services to both Medicare and non-Medicare patients.

Various types of medical care are provided by the hospital. The category of care involved in this case consists primarily of the services of radiologists but also include pathologists,

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[1] P.L. 89-97, July 30, 1975, now codified, as amended, as Subchapter XVIII of the Social Security Act, 42 U.S.C. §§ 1395-1395pp. All statutory citations are to Title 42 unless otherwise indicated.

[2] The complaint contained three counts. Briefly stated, count I alleged violations of applicable statutes and regulations; count II alleged denial of procedural due process; and count III alleged denial of equal protection. For greater detail, *see* p.6 *infra*.

anesthesiologists, and others. Physicians on the staff of St. Louis University who provide these services to hospital patients also perform teaching duties. In compensation for all their medical and teaching services, they receive a salary from St. Louis University.

Prior to the advent of Medicare in 1966, patients of the St. Louis University Hospital received a hospital bill which contained a single charge for this type of medical care. Taking radiology services as an example, that single charge to the patient included two unidentified components: (1) the charge for technicians, equipment, and overhead used in providing X-rays, and (2) the professional charge of the radiologist.

The Medicare program requires that these components be isolated and treated differently. The first component is termed the "provider component" and provides reimbursement for those types of services which normally are furnished by the hospital itself. This charge is covered by part A of the Medicare program. 42 U.S.C. §§ 1395c-1395i. The second is termed the "professional services component." The professional services component is insured and compensated under part B of the Medicare program. 42 U.S.C. § 1395j-1395w. The Medicare Act provides that the amount of reimbursement under part A (provider component) must be determined on the basis of the "reasonable cost" of such services to the provider; under part B (professional services) the basis is the "reasonable charge."

After the enactment of the Medicare Act, the St. Louis University hospitals adopted an internal accounting procedure which segregated the provider and professional services components on the hospitals' books but not on the patient's bill. Despite this new accounting procedure and even though the professional services component was no greater than the admittedly reasonable charges made by physicians in other area hospitals, the University's claim for reimbursement was disallowed to the ex-

tent that the professional services component exceeded the actual cost of the services to the hospital based on a pro rata allocation of the salary of the physicians in question. The University was required to refund to HEW all amounts received under part B which exceeded the salary amount.

Not all physicians on the teaching staff of the University hospitals bill patients through the hospitals. Teacher-physicians in certain specialties traditionally have made charges directly to the patient for their services. For example, surgeons bill the patient directly for an operation, notwithstanding that the surgeon is also a salaried member of the University's teaching staff. The surgeon's bill is paid directly to him by the Medicare carrier, and the surgeon turns the payment directly over to the University. In turn, the University pays the surgeon a salary. Where billing is done in this manner, Medicare pays the surgeon's entire bill, provided it is reasonable, even though it exceeds his salary.

In some other hospitals radiologists and related specialists customarily bill the patient directly. In those cases, Medicare pays the full reasonable charge even though it exceeds the radiologist's salary. This also is true even if the hospital does the actual billing so long as a separate charge for the physician's services (including radiological and similar services) is set out on the patient's bill and provided that this practice was followed prior to the enactment of Medicare. However, if a hospital did not identify a separate professional services component on the patient's bill prior to Medicare, it cannot obtain full reimbursement by now adopting such a procedure.[3]

Some explanation must be made of the system by which disputes with regard to Medicare payments are resolved. The Blue

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[3] In this summary of the facts we describe the regulatory scheme as it has been administratively interpreted in this case, explained in the defendants' briefs, and applied to the University. Our statements here should not be taken as expressing any view of the proper interpretation of the regulations.

Cross Association (BCA) was nominated by the University Hospitals to serve as their fiscal intermediary with HEW. BCA delegated its duties as intermediary to the Blue Cross Hospital Service, Inc. (the Plan), which is a local Blue Cross group in St. Louis. Part B of the Medicare Act is administered through an insurance carrier under the part B supplemental program. That insurance carrier in this case is General American Life Insurance Company. BCA entered an agreement with the Secretary establishing a five-member Provider Appeal Committee (the Committee). The Committee was to hear appeals by providers who were dissatisfied with the reimbursement allowed by BCA. The agreement required that three of the Committee members be BCA employees—one a BCA vice-president. The other two were appointed by the BCA president from nominees of various national associations of providers. Decisions of the Committee were by majority vote. The agreement specified that decisions of the Committee would be absolutely final.[4]

The University's claim for reimbursement under part B of an amount which its internal bookkeeping identified as the charge for professional services such as those of radiologists, was accepted and paid by the insurance carrier, General American, but later, after an audit, was disallowed by the Plan. The Plan has the responsibility for auditing Medicare payments approved by the carrier. The Plan determined that the University's right to reimbursement under part B for services provided by those specialists who bill through the hospital was limited to the pro rata salary paid to those physicians.

The University appealed to the BCA Provider Appeals Committee. The Committee unanimously affirmed the Plan's decision.

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[4] The appointment of fiscal intermediaries is authorized by § 1395h(a). Providers have the option of not nominating an intermediary and dealing directly with HEW. However, HEW concedes that the use of an intermediary confers significant benefits. Evidently some providers choose to forego these benefits and deal directly with HEW.

When the University lost its appeal before the Committee, it brought this action in district court against BCA, the Plan, and the Secretary of HEW. As we have already noted, *see* note 2 *supra*, the complaint contained three counts. Count I alleged that the Committee's decision violated the Medicare Act and regulations promulgated thereunder. Count II alleged that the makeup of the Committee was unfair and improper and thus violated procedural due process. Count III alleged that essentially identical claims of other providers processed through a different bookkeeping procedure had been approved and paid by Blue Cross and HEW, that this distinction was not rationally related to any legitimate governmental objective, and that the University therefore had been arbitrarily and capriciously denied the equal protection of the law.

In ruling on cross-motions for summary judgment, the district court dismissed counts I and III for lack of jurisdiction due to sovereign immunity since those counts sought a money judgment, but granted the University relief on count II for denial of procedural due process. The district court determined that the Committee, consisting as it did of a majority of BCA employees, could not afford an impartial hearing to the University. By way of relief, the district court remanded the University's appeal to the Secretary for a *de novo* evidentiary hearing before a tribunal not containing employees of the BCA. The district court also concluded that the Medicare Act and due process required the Secretary of HEW to review the record of the hearing afforded the plaintiff, citing 42 U.S.C. § 1395h(a). We essentially affirm the district court but on different grounds.

II. **Federal Question Jurisdiction Under § 1331.**

In examining our federal question jurisdiction alleged by appellant under § 1331, we are met with the provisions of 42 U.S.C. § 405(h). This section is part of the Social Security

Act, but is incorporated "to the same extent as they are applicable" into the Medicare Act by 42 U.S.C. § 1395ii. Section 405(h) provides:

> [1] The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. [2] No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. [3] No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 [§ 1331] of Title 28 to recover on any claim arising under this subchapter.

The Supreme Court in *Weinberger v. Salfi*, 422 U.S. 749 (1975), discussed the jurisdictional bar imposed by this statute to parties who challenged on constitutional grounds those provisions of the Social Security Act which require that the relationship between a wage earner and his wife or step-children must have existed for a fixed time prior to his death as a condition for receiving benefits. The Court reached the merits only with respect to those named individual plaintiffs who had satisfied the requirements of § 405(g) which authorizes judicial review. It dismissed the class action for want of federal question jurisdiction, noting that no allegation was made that class members had exhausted their administrative remedies as required by § 405(g). *Id.* at 764.[5]

In the course of its decision, the Court specifically examined § 405(h). The Court focused on the third sentence of § 405 (h) which forbids any action "against the United States, the Secretary, or any officer and employee thereof" brought under § 41

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[5] The University urges that § 405(g) was incorporated by § 1395 ii. However, § 1395ii lists those specific subsections of § 405 which it intends to incorporate and § 405(g) is conspicuously omitted. Further, such a finding would render superfluous § 1395ff(b) which authorizes some limited review and which partially incorporates § 405(g). *See* p. 11 *infra*.

[now § 1331] of Title 28 "to recover on any claim arising under this subchapter." The Court rejected the view expressed by many federal courts that § 405(h) merely required exhaustion of administrative remedies.[6] The *Salfi* Court said:

> That the third sentence of § 405(h) is more than a codified requirement of administrative exhaustion is plain from its own language, which is sweeping and direct and which states that *no* action shall be brought under § 1331, not merely that those actions shall be brought in which administrative remedies have been exhausted. Moreover, if the third sentence is construed to be nothing more than a requirement of administrative exhaustion, it would be superfluous. This is because the first two sentences of § 405(h) * * * assure that administrative exhaustion will be required. [*Id.* at 757 (emphasis in original) (footnote omitted).]

Appellees in *Salfi* argued that they did not seek to "recover on any claim" under the Social Security Act but rather sought to recover under the Constitution. The Supreme Court conceded this argument had some substance, *id.* at 760-62, noting *Johnson v. Robison*, 415 U.S. 361 (1974). However, the Court said that it was "Social Security benefits which appellees seek to recover," *id.* at 760, and that

> [t]o contend that such an action does not arise under the Act whose benefits are sought is to ignore both the language and the substance of the complaint and judgment. [*Id.* at 761.]

Hence, the claims of the class were held to be barred by §405(h) since, due to failure to exhaust administrative remedies, review under §405(g) was improper. The Court said that the reach of §405(h)

> extends to any "action" seeking "to recover on any [Social Security] claim"—irrespective of whether resort to

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[6] *See, e.g.*, cases cited at note 7 *infra*.

> judicial process is necessitated by discretionary decisions of the Secretary or by his nondiscretionary application of allegedly unconstitutional statutory restrictions. [422 U.S. at 762.]

The considerations which led Congress to limit review under the Social Security Act apply with equal force to the Medicare program.

The Medicare statute is a complicated one. Judicial review of the amount of all Medicare payments would bring the courts into the complex interplay between physician and hospital in ascertaining the appropriate medical charges for technical services—based on facts which vary from community to community. These charges are subject to extensive and complicated statutory guidelines and regulations. *See, e.g.*, 42 U.S.C. §§1395ff, 1395p, 1395u; 20 C.F.R. §405 *et seq.* Determining the proper amount of these charges is a matter peculiarly suited to determination by a specialized agency.

Section 405(h) should be read with these complications in mind. We think *Salfi* requires us to follow it literally. The Supreme Court's approach to §405(h) in *Salfi* varies substantially from the approach taken by those cases which have found jurisdiction. The citation of *Cappadore v. Celebrezze*, 356 F.2d 1 (2d Cir. 1966), in Justice Brennan's dissenting opinion demonstrates that the reasoning of those cases was considered by the Court and bolsters our conclusion that they are consistent with the *Salfi* decision.[7] Accordingly, we reject the authority of those pre-*Salfi* cases relied upon by the Uni-

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[7] *See id.* at 787 n.2 (Brennan, J., dissenting). Plaintiffs also placed heavy reliance upon *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663 (3d Cir. 1973), and *Aquavella v. Richardson*, 437 F.2d 397 (2d Cir. 1971). These are direct offspring of the *Cappadora* decision. *Rothman v. Hospital Service*, 510 F.2d 956 (9th Cir. 1975), also relies heavily on the *Cappadora* line of cases. The Fifth Circuit appears to have simply assumed jurisdiction. *Mount Sinai Hosp. v. Weinberger*, 517 F.2d 329 (5th Cir. 1975), *cert. denied*, — U.S. — ( ).

versity.[8] Since count I sought to obtain payments pursuant to the Medicare Act, §405(h) precludes the federal courts from assuming jurisdiction under §1331. Count III seeks similar relief and also would appear to be barred. However, it purports to raise a constitutional equal protection claim. We discuss this aspect of count III in a subsequent portion of this opinion.

III. **Jurisdiction Under the APA.**

The University asserts that jurisdiction is established independently of § 1331 by the Administrative Procedure Act, 5 U.S.C. §§ 702-06. While there is some doubt whether the APA in and of itself affords an independent basis for federal court jurisdiction, in this particular case § 702 of the APA would preclude finding jurisdiction in any event. The APA provides that if agency action is "committed" to the discretion of the administrator, it is not subject to judicial review under the APA.[9] *See generally Greater New York Hospital Association v. Matthews*, — F. Supp. —, 44 U.S.L.W. 2337 (S.D. N.Y., Dec. 11, 1975).

To determine whether Congress intended to commit the issues raised by the University to agency discretion we must carefully examine the Medicare Act. The provision governing

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[8] We are aware that Congress has amended the Medicare Act to create a Provider Reimbursement Review Board whose decisions specifically are made judicially reviewable under the APA. 42 U.S.C. § 1395oo (1970) (Supp. III). This does not alter our view of the prior legislative intent. The amendment is applicable only to accounting periods ending on or after June 30, 1973.

[9] 5 U.S.C. § 702. Of course, § 706(2)(A) authorizes a reviewing court to remedy an "abuse of discretion." Thus, all agency discretion is not insulated from judicial review. The crucial question in each case is whether the matter is sufficiently *committed* to agency discretion as to preclude review. *See* Davis, Administrative Law Treatise § 28.16 at 80-81, and 1970 Supplement § 28.16 at 964-65.

the availability of judicial review in this case appeared in the original Medicare Act. It provided for judicial review on behalf of an individual of

> [a]ny determination [by the Secretary] * * * as to entitlement under Part A or Part B or as to amount of benefits under Part A * * *. [42 U.S.C. § 1395ff(b) (1970).]

The conspicuous omission of any provision for judicial review of the *amount* of benefits under part B indicates that Congress felt that determination of the proper "reasonable charge" was a matter best left to agency expertise. *Cf. Schillings v. Rogers*, 363 U.S. 666, 674 (1960).

Our view is strengthened by the emphatic language of § 405(h) which forbids bringing "any claim under § 41 of Title 28." The Supreme Court observed in *Salfi* that at the time § 405(h) was adopted

> prior to the 1948 recodification of Title 28, § 41 contained all of that title's grants of jurisdiction to United States district courts, save for several [irrelevant] special purpose * * * grants * * *. [422 U.S. at 756 n.3.]

Thus, by precluding any resort to § 41, § 405(h) completely eliminated all then existing jurisdictional bases for judicial review. This demonstrates a congressional intent to commit maximum discretion to the Secretary.

The University asserts that whatever the Secretary's discretion within statutory confines, he has so far exceeded the statute as to compel judicial intervention. We therefore turn to the statute and implementing regulations. Section 1395*l* of Title 42 authorizes reimbursement in full of the "reasonable charges" for compensable part B professional services. The implementing HEW regulations appear at 20 C.F.R. § 405.480 *et seq*. They are amplified in detail in § 3906.2 and § 3906.3 of part A, Intermediary Manual. Section 3906.2 states in part:

> Where provider has customarily identified a physician's charges separately from charges for provider services, the physician's charges so established will be considered the customary charges for his professional services, and will afford the basis for determining the reasonable charges for such services.

In contrast, § 3906.3 states in part:

> Where, under an existing arrangement between a provider and physician, billings to patients have not separately identified charges of physician's services and charges for provider services a schedule charge will need to be developed based on the physician's professional component.

The Committee read these two regulations together and reached this conclusion:

> These two sections, then, reiterate the two alternatives available. In effect, either the provider or physician has established the charge or they have not established a separate charge for the physician's services. If they have, that charge is the basis for Part B reimbursement for physician's services; if they have not, a charge is developed (for Medicare reimbursement purposes) based upon the physician's compensation attributable to patient care services. A separate charge has been established when the billings by the hospital have shown a separate charge for the physician's service. This charge must be separated on all billings to patients and third party payors. Only by billing all patients this separate charge can it be established as a charge for that particular service.

The University reads these regulations as interpreted by the Committee as a flat rejection of the mandatory statutory standard of "reasonable charges." HEW, on the other hand, asserts that these regulations do not reject the statutory standard but

merely define it. Obviously, there are limits to an agency's definitional leeway.[10] However, we cannot say that the Committee's interpretation of the regulations which HEW defends in this case is so arbitrary and capricious as to compel us to intervene. The Committee's decision and the underlying regulations appear on their fact to be an attempt to define the statutory language. As we hold in part IV of this opinion, it is the duty of the Secretary to review the Committee's action to assure that it comports with the Medicare Act and its implementing regulations. We cannot assume that the Secretary will so abuse the discretion conferred upon him by the Medicare Act as to place his decision outside the purview of § 405(h). Our discussion here carries no implication relating to the merits of St. Louis Hospital's claim for reimbursement.

IV. **Jurisdiction to Require Procedural Due Process (Count II).**

However, even though we conclude that Congress intended to commit the determination of the proper *amount* of reimbursement wholly to administrative discretion, we must still face the University's claim under count II that Congress did not and could not approve the administrative process employed in this case. The University points out that HEW subjected it to

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[10] The limits of the right to define have never been exactly determined. Early sources indicate that the question is not new. Consider, for example, the following dialogue:

> "When I use a word," Humpty Dumpty said in a rather scornful tone, "it means just what I choose it to mean—neither more or less."
>
> "The question is," said Alice, "whether you *can* make words mean so many different things."
>
> "The question is," said Humpty Dumpty, "which is to be master—that's all. * * * They've a temper, some of them—particularly verbs, they're the proudest—adjectives you can do anything with, but not verbs—however, *I* can manage the whole lot of them! Impenetrability! That's what *I* say!"
>
> "Would you tell me, please," said Alice, "what that means?" [L. Carroll, *Through the Looking Glass*, Ch. 6 (emphasis in original).]

the bureaucratic whim of a nongovernmental Provider Appeals Committee, a majority of the members of which were officers or employees of BCA whose initial decision was being appealed, and who had an institutional interest in the outcome.[11] According to HEW's view, the Committee's discretion is essentially unrestrained. Judicial review is barred by § 405(h) and administrative review is precluded by the agreement between HEW and BCA which established the Committee. HEW will not review the Committee's decision even when a provider asserts that the Committee has blatantly ignored governing statutes, regulations, and constitutional requirements.

The Supreme Court has recognized that totally precluding judicial consideration of constitutional issues raises serious constitutional problems. *Weinberger v. Salfi, supra,* 422 U.S. at 762; *Johnson v. Robison,* 415 U.S. 361, 366 and n.8 (1974). Those constitutional problems are greatly intensified when an agency purports to subdelegate its immunity from judicial review to a nongovernmental entity. It is a "cardinal principle" that we are to ascertain whether a construction of the statute involved is "fairly possible" by which such constitutional doubts may be avoided. *Johnson v. Robison, supra,* 415 U.S. at 366-67. We are to proceed in what Justice Stewart termed "the candid service of avoiding a serious constitutional doubt." *United States v. Vuitch,* 402 U.S. 62, 97 (1971) (Stewart, J., dissenting in part).

Thus, we must now return to § 405(h) to determine if it precludes our jurisdiction to entertain a due process challenge to the procedures adopted by the Secretary to determine Medi-

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[11] The intangible effect of institutional loyalty must not be underestimated simply because it is difficult to quantify. *See* H. Simon, Administrative Behavior 13-14 (1957), *quoted in* W. Gellhorn & C. Byse, Administrative Law: Cases & Comments 881 (5th Ed. 1970). As Justice Jackson commented, "Men are more often bribed by their loyalties and ambitions than by money." *United States v. Wunderlich,* 342 U.S. 98, 103 (1951). *See also Goldberg* v. Kelly, 397 U.S. 254, 271 (1970).

care reimbursements. Section 405(h) forbids any action under § 1331 "to recover on any claim arising under this subchapter." Appellees in *Salfi* argued that this did not bar their constitutional claims since they "arose under" the Constitution and not under the Social Security Act. The Supreme Court recognized that this argument had substance. 422 U.S. at 760. However, it rejected the argument because

> not only is it Social Security benefits which appellees seek to recover, but it is the Social Security Act which provides both the standing and the substantive basis for the presentation of their constitutional contentions. [*Id.* at 760-61.]

The Court also indicated that its decision was influenced by the availability of fully adequate judicial review under § 405(g). The Court said:

> In th resent case * * * the Social Security Act itself provides jurisdiction for constitutional challenges to its provisions. *Thus* the plain words of § 405(h) do not preclude constitutional challenges. [*Id.* at 762 (emphasis added).]

In the present case, the due process claim has as its primary goal obtaining a constitutionally adequate hearing. Allowing such a hearing will not necessarily affect the University's entitlement to reimbursement or the amount allowed. Secondly, and more importantly, the Medicare Act does not provide the University an adequate alternative means of obtaining judicial review of its due process claim.

We believe that on these two grounds alone, this case is distinguishable from *Salfi*, and thus §405(h) does not preclude our jurisdiction of count II.[12] However, there is a third

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[12] The Supreme Court has recently found jurisdiction to review a Social Security beneficiary's claim of a denial of due process. *Mathews v. Eldridge*, — U.S. —, 44 U.S.L.W. 4224 (U.S. Feb. 24, 1976). The Court emphasized that the due process claim was "collateral to his substantive claim of entitlement" and that no other fully effective review was available. *Id.* at . . . .

basis for distinction. Section 405(h) is incorporated into the Medicare Act only "as * * * applicable." §1395ii. The general rule is that a statute incorporated into another "as applicable" will be read in such a manner "as will give form and effect to the statute into which it is incorporated." *Penrose v. Whiteacre*, 147 P.2d 887, 889 (Nev. 1944), and authority cited therein. If §405(h) were read to wholly preclude adjudication of the University's due process claim it would raise serious constitutional problems which might impair the force and effect of the Medicare Act. Therefore, we find that Congress did not intend for §405(h) to apply to the Medicare Act in such a manner as to completely bar judicial consideration of a claim of denial of due process.

On the merits of count II, the district court made the following finding:

> Three of the five Board members who conducted the subject hearing, Chairman Green, Hankle, and Moeller, were BCA employees. BCA had advised the Plan in 1969 on the merits of plaintiff's position and was supportive of the Plan's ultimate decision. Furthermore, BCA was co-contractor with the Plan in providing the intermediary services to plaintiff and the Secretary. The conclusion is inescapable that plaintiff was not afforded a hearing before an impartial decision maker.

The court also found that "both the Medicare Act, 42 U.S.C. §1395h(a) (1965), and the constraints of due process require that the Secretary review the record of any hearing afforded plaintiff." As a remedy the court remanded the case to the Secretary "for a *de novo* evidentiary hearing before a tribunal that does not contain employees of BCA."

While we appreciate the district court's concern over the BCA personnel serving on the Committee, we find that the makeup of the Committee was constitutionally permissible. *See*

Winthrow v. Larkin, 421 U.S. 35 (1975). Moreover, all parties to this appeal seem agreed that the facts are undisputed. Thus, we cannot see that the Committee's factfinding function prejudices the University in any way.

However, the parties do dispute the proper intrepretation of the HEW regulations and whether these regulations are consistent with the Medicare Act. We agree with the district court that due process precluded vesting the final determination of these issues in the Committee as constituted and we doubt that Congress authorized any such delegation of power.[13]

Thus, we modify the judgment of the district court by eliminating the requirement that the Secretary hold a *de novo* evidentiary hearing. While on remand the Secretary may hold such an evidentiary hearing if it is thought desirable, we direct only that the Secretary adopt and employ appropriate measures to determine the University's contentions concerning the proper interpretation of the Medicare Act and regulations.

V. **Jurisdiction to Require Equal Protection (Count III).**

Finally, we must consider count III in which the University advances an equal protection claim. The University asserts

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[13] Section 1395(a) authorizes the Secretary to:

> enter into an agreement with [a fiscal intermediary like BCA] providing for the determination by such agency or organization (*subject to* the provisions of section 1878 [42 U.S.C. § 1395oo] and to *such review by the Secretary as may be provided for by the agreement*) of the amount of payments required * * *. (Emphasis supplied).

HEW reads the language included in parenthesis to allow the Secretary to enter an agreement which precludes any administrative review whatsoever of a fiscal intermediary's determination. However, this takes the parenthetical too far. The statute may well permit an agreement authorizing a properly constituted intermediary to make final factual determinations. However, the general scheme of the statute requires that the Secretary retain sufficient powers of review to assure that fiscal intermediaries comply with HEW regulations and the Medicare Act.

that the Committee acted arbitrarily and capriciously by disallowing its claim while allowing identical claims of other providers similarly situated who merely happen to have a different bookkeeping system.

On its face this appears to raise a constitutional issue.[14] The Due Process Clause of the fifth amendment has been held to embody a guaranty of equal protection by the federal government. *See United States Dept. of Agriculture v. Moreno*, 413 U.S. 528, 533, n. 5 (1973). Traditionally, equal protection analysis has required that a governmental classification be "rationally related to a legitimate governmental objective." *Id.* at 533.

Much of our jurisdictional analysis of the procedural due process issue presented in count II would seem to support our jurisdiction of count III, which also arises under the due process guaranty of the fifth amendment. If §405(h) bars our jurisdiction, the University will have no judicial forum in which to assert its constitutional right to equal protection.

On the other hand, the direct purpose of this claim is to increase the amount of reimbursement to the University. Thus, it appears to fall squarely within the language of §405(h) and of the Supreme Court in *Salfi*. 422 U.S. at 760-62. Additionally, count III seeks a money judgment against the United States. The doctrine of sovereign immunity probably would permit the Congress to forbid such an action even if based upon a constitutional violation. *See Dugan v. Rank*, 372 U.S. 609, 620 (1963); *cf. Edelman v. Jordan*, 415 U.S. 651 (1974).

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[14] The University's complaint in this case is at least somewhat more specific than the conclusory allegations in *Schilling v. Rogers*, 363 U.S. 666 (1960), that the administrative action was "arbitrary and capricious."

We need not reach this difficult issue at this time. Pursuant to count II, we have determined that this case should be remanded to the Secretary for his consideration of the University's position. Consideration of the issues raised in count III must await the Secretary's hearing and decision on the University's claim.[15]

Postponing a decision on count III offers several advantages. In count I, the University has argued that under the proper interpretation of HEW's regulations, it is entitled to full reimbursement. The Secretary may agree. If so, a judicial resolution of the difficult issues presented by count III will be unnecessary. On the other hand, if the Secretary rejects the University's claim, the count III jurisdictional issue will be squarely presented. Should jurisdiction be found, judicial assessment of the merits of the claim will be made substantially easier by the Secretary's authoritative construction of the regulations and articulation of their underlying rationale.

Therefore, we make the following disposition of this appeal:

1) The district court's dismissal of count I for lack of jurisdiction is affirmed for the reasons discussed above;

2) The district court's judgment granting relief on count II is modified by eliminating the requirement of a *de novo* evidentiary hearing before a tribunal that does not include members of BCA, but is affirmed to the extent that it requires the Secretary to make a final administrative determination of the medical fee dispute between appellant and appellees;

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[15] As noted in our discussion of count II, the extent of Congress' power to preclude judicial consideration of constitutional issues is itself a difficult constitutional question which has never been clearly resolved by the Supreme Court. It is the settled federal practice to postpone resolving such constitutional issues until a decision is necessary. *Sullivan v. Meade County School Dist. 101*, — F.2d —, 44 U.S.L.W. 2424 (8th Cir., Feb. 26, 1976).

3) The district court's dismissal of count III is affirmed on the ground that it is premature but without prejudice to a later action raising the equal protection clause.

A true copy.

Attest:

Clerk, U. S. Court of Appeals, Eighth Circuit

APPENDIX C

United States Court of Appeals
For the Eighth Circuit

September Term, 1975

75-1274 St. Louis University, etc., Appellee, vs. Blue Cross Hospital Service, Inc., et al., Appellants. 75-1293 St. Louis University, etc., Appellant, vs. Blue Cross Hospital Service, Inc., et al., Appellees.	Appeals from the United States District Court for the Eastern District of Missouri

The Court having considered petition for rehearing en banc filed by counsel for appellee-appellant, St. Louis University and, being fully advised in the premises, it is ordered that the petition for rehearing en banc be, and it is hereby, denied.

Considering the petition for rehearing en banc as a petition for rehearing, it is ordered that the petition for rehearing also be, and it is hereby, denied.

May 4, 1976

APPENDIX D

Title 5 U.S.C. § 701(a)

(a) This chapter applies, according to the provisions thereof, except to the extent that—

(1) statutes preclude judicial review; or

(2) agency action is committeed to agency discretion by law.

Title 5 U.S.C. § 702

Right of Review

A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof.

Title 5 U.S.C. § 704

Actions Reviewable

Agency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court are subject to judicial review. A preliminary, procedural, or intermediate agency action or ruling not directly reviewable is subject to review on the review of the final agency action. Except as otherwise expressly required by statute, agency action otherwise final is final for the purposes of this section whether or not there has been presented or determined an application for a declaratory order, for any form of reconsideration, or, unless the agency otherwise requires by rule and provides that the action meanwhile is inoperative, for an appeal to superior agency authority.

Title 28 U.S.C. § 1331(a)

(a) The district courts shall have original jurisdiction of all civil actions wherein the matter in controversy exceeds the sum or value of $10,000, exclusive of interest and costs, and arises under the Constitution, laws, or treaties of the United States.

Title 42 U.S.C. § 405(g)

Judicial review

(a) Any individual, after any final decision of the Secretary made after a hearing to which he was a party, irrespective of the amount in controversy, may obtain a review of such decision by a civil action commenced within sixty days after the mailing to him of notice of such decision or within such further time as the Secretary may allow.

Title 42 U.S.C. § 405(h)

Finality of Secretary's decision

(h) The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 to recover on any claim arising under this subchapter.

Title 42 U.S.C. § 1395 l

Payment of benefits—Amounts

(a) Except as provided in section 1395mm of this title, and subject to the succeeding provisions of this section, there shall

be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1395k(a)(l) of this title—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b) of this section, (B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology, the amounts paid shall be equal to 100 percent of the reasonable charges for such services.

Title 42 U.S.C. § 1395 u

In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

APPENDIX E

¶ 27,819 Jurisdiction of the Court—Retroactive Corrective Adjustment

Whitecliff, Inc., d/b/a White Cliff Manor v. U. S. U. S. Court of Claims, No. 407-74, May 12, 1976. Before COWEN, Chief Judge, DAVIS and KASHIWA, Judges.

Notices, determinations and appeals—Judicial review of intermediaries' reimbursement determinations.—Jurisdiction exists to review the merits of a reasonable cost determination under the Medicare Act. In cases where the Medicare statute provides for review, providers and courts must follow the specified procedures and limitations; in other cases, a provider may obtain judicial review under general jurisdictional provisions to ensure compliance with statutory and constitutional standards. The decision in *Weinberger v. Salfi*, 422 U. S. 749 (1975), should not be extended to cases arising under the Medicare statute because of the extremely limited provisions of the Act for provider review. Therefore, a provider that contends that reimbursements were inadequate and less than its actual costs is entitled to judicial review of its claim for a retroactive corrective adjustment. *Back references:* ¶ 13,510, 13,510.75.

Provider reimbursement—Payments to providers—Retroactive corrective adjustment.—A provider is entitled to retroactive adjustment in its reimbursement if it can prove that actual reasonable cost for a reporting period exceeded its reimbursement. The Secretary may not defeat his duty to make such corrective adjustments by approving only methods of cost determination—i.e., the "Departmental RCCAC" and "Combinations" methods of cost apportionment—which lead to inadequate reimbursements in particular cases or by promulgating regulations which allow only for a prospective change of accounting methods for determining costs. *Back references:* ¶ 7330, 7350A.

[Text of Decision]

DAVIS, Judge, delivered the opinion of the court:

This controversy between a provider of services under the Medicare program and the Government presents primarily a dispute over 42 U. S. C. § 1395x(v)(1) (1970),[1] relating to the reimbursement to be made to a Medicare provider. Both parties have moved for summary judgment but we find that we cannot dispose of the case finally.

By contract accepted by the Government in 1966, plaintiff Whitecliff, Inc., operating an extended care facility, became a Medicare provider and thus entitled to reimbursement by the Government for reasonable costs incurred in giving services to Medicare beneficiaries. Whitecliff designated the Blue Cross Association (BCA) and Blue Cross of Northern Ohio (BCNO) as its fiscal intermediaries.[2]

In 1970 Whitecliff instituted a work measurement program which purportedly revealed that its actual Medicare costs for 1967-1970 exceeded the reimbursement received from the Government. Whitecliff submitted a request for a retroactive adjustment under 42 U. S. C. § 1395x(v)(1) to correct the alleged inadequate reimbursement. BCNO and BCA each denied the request, and Whitecliff appealed to the BCA Medicare Provider Appeals Committee, in accordance with a disputes procedure established by the BCA in 1968. After a hearing, the Appeals Committee upheld BCA's denial of the claim. Whitecliff then

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[1] Statute citations are to the 1970 *Code* unless otherwise noted, because later amendments are inapplicable to this case. All section citations, standing alone, are to title 42 of the *Code*.

[2] A fiscal intermediary is a public agency or private organization which contracts with the Secretary of Health, Education, and Welfare, under 42 U. S. C. § 1395h(a), to determine the amount of reimbursement to be paid to providers and to make payments. The contract may require the intermediary to perform additional services. See 42 U. S. C. §§ 1395h(a), (c).

filed suit in this court for $213,755, the amount of the alleged underpayment, asserting that it is entitled to a retroactive adjustment and that it was denied due process because the BCA Medicare Provider Appeals Committee was not an impartial decision-maker. The Government defends on the grounds, first, that the social security statute precludes any judicial review of the intermediaries' reimbursement determinations, and, second, that plaintiff's arguments have no merit.

[*Judicial Review of Intermediaries' Reimbursement Determinations*]

A number of courts have considered the permissibility and scope of judicial review of Medicare provider reimbursement disputes. No consensus has emerged on whether courts may review the merits of reasonable cost determinations (*see, e.g., Schroeder Nursing Care, Inc. v. Mutual of Omaha Ins. Co.*, 311 F. Supp. 405, 408-09 (E. D. Wis. 1970) (court may not review amount determined to be reasonable cost); *Temple Univ. v. Associated Hosp. Serv.*, 361 F.Supp. 263, 267-70 (E. D. Pa. 1973) (court had jurisdiction to review merits of determination that a certain transfer of funds was restricted and therefore deductible from Medicare reimbursement); *Coral Gables Convalescent Home, Inc. v. Richardson*, 340 F.Supp. 646, 650 (S. D. Fla. 1972) (court could not make *de novo* reasonable cost determination, but court suggested that it might review for substantial evidence after an administrative hearing was held)), but the courts have uniformly sustained judicial review at least for compliance with the Constitution and the governing statute. *See, e.g., Aquavella v. Richardson*, 437 F.2d 397, 400-02 (2d Cir. 1971); *Kingsbrook Jewish Medical Center v. Richardson*, 486 F.2d 663, 666-68 (2d Cir. 1973); *Rothman v. Hospital Serv.*, 510 F. 2d 956, 958-60 (9th Cir. 1975); *Schroeder Nursing Care, Inc. v. Mutual of Omaha Ins. Co., supra* at 409; *Americana Nursing Centers, Inc. v. Weinberger*, 387 F. Supp. 1116, 1118-19 (S. D. Ill.

1975); *South Boston Gen. Hosp. v. Weinberger*, 397 F. Supp. 360 (W. D. Va. 1975). We accepted this scope of review in our order in *Goldstein v. United States*, 201 Ct. Cl. 888, *cert. denied*, 414 U. S. 974 (1973).

The Government contends, however, that the Supreme Court's recent decision in a social security benefits case, *Weinberger v. Salfi*, 422 U. S. 749 (1975), implicitly overruled these prior decisions and endorsed the Government's position that there is no review at all of Medicare provider determinations such as the one now before us. In *Salfi* the Supreme Court ruled that 42 U. S. C. § 405(h)[3] precludes district court review of social security benefit decisions, except insofar as review is authorized elsewhere in the Social Security Act. *Id.* at 756-63. Because Section 1395ii of 42 *United States Code* makes Section 405(h) applicable to the Medicare program, the Government argues that Section 405(h), as interpreted in *Salfi*, prohibits judicial review of all Medicare determinations other than those few for which the act expressly provides review. For the years in question, the act explicitly treats judicial scrutiny of specified Medicare determinations only in 42 U. S. C. § 1395ff, which does not authorize review of the type of decision appealed by plaintiff.[4]

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[3] Section 405(h) states:

"The findings and decisions of the Secretary after a hearing shall be binding upon all individuals who were parties to such hearing. No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or government agency except as herein provided. No action against the United States, the Secretary, or any officer or employee thereof shall be brought under section 41 of Title 28 [now the sections of Title 28 delimiting district court jurisdiction] to recover on any claim arising under this subchapter."

[4] 42 U. S. C. § 1395ff(c) entitles an institution to a hearing by the Secretary and to judicial review under Section 405(g) only after a decision to terminate the institution as a provider of services or a determination that the institution is not a provider of services. Other parts of 1395ff cover the rights of individual Medicare beneficiaries to hearings and appeals.

In 1972 and 1974, Congress enacted provisions and amendments greatly expanding statutory review of Medicare provider reimburse-

We decline the invitation to extend *Salfi's* reading of Section 405(h) to this Medicare case. The social security provisions with which the Supreme Court dealt in *Salfi* authorize appeals of all decisions made after hearings, with out limitation as to issues;[5] the practical effect of the *Salfi* decision was simply the enforcement of the Section 405 (g) procedures and prerequisites to judicial review. *See also Mathews v. Eldridge*, U. S. Sup. Ct. No. 74-204, decided Feb. 24, 1976 (slip op. at 4-10). By contrast, the Medicare statute's express review provisions in effect prior to 1973 apply to extremely limited categories of cases involving providers.[6] To import into the Medicare program the *Salfi* preclusion of judicial review (except as expressly authorized) would be to prevent all review of very large categories of cases and issues, including constitutional questions, and to accord absolute finality to adjudications by private organizations like the BCA. Such a result would be of doubtful constitutional validity and would undermine the normal presumption in favor of judicial review.[7] We cannot assume that the Supreme Court

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ment determinations. An amendment of 1972 established a Provider Reimbursement Review Board with jurisdiction to renew reimbursement disputes where the amount in controversy exceeds $10,000. Social Security Amendments of 1972, § 243, 86 Stat. 1420, 42 U. S. C. § 1395oo. In 1974 Congress enlarged the review provision of 1395oo to grant providers the right to obtain judicial review, in a district court, of any decision of the statutory Board and of any reversal, affirmance, or modification of the Board's decision by the Secretary, Pub. L. No. 93-484, § 3(a), 88 Stat. 1459 (1974), 42 U. S. C. § 1395oo (f)(1). These provisions apply only to cost reporting periods ending on or after June 30, 1973.

[5] Section 405(g) entitles any individual who was a party to a hearing to appeal any final decision made after a hearing. Because Section 405(b) entitles any individual prejudiced by an initial decision on an application for benefits to a hearing, the review secured by Section 405(g) potentially covers every benefits decision.

[6] See note 4 *supra*.

[7] See generally *Johnson v. Robison*, 415 U. S. 361, 366-68, 373-74 (1974); *Barlow v. Collins*, 397 U. S. 159, 166-67 (1970); *Kingsbrook Jewish Medical Center v. Richardson*, 486 F. 2d 663, 667-68 (2d Cir. 1973); Homer & Platten, *Medicare Provider Reim-*

would extend the *Salfi* interpertation of Section 405(h) to Medicare cases, where the consequences would be so dramatically different, and therefore we adhere to the pre-*Salfi* view of judicial review of Medicare provider disputes: where the Medicare statute provides for review, providers and courts must follow the specified procedures and limitations; in other cases, a provider may obtain judicial review, under the general jurisdictional provisions which are applicable, at least so far as to ensure compliance with statutory and constitutional provisions.[8] In this court, 28 U. S. C. § 1491 (the Tucker Act) is the pertinent jurisdictional provision both because of plaintiff's contract with the Government and also because the Medicare legislation, fairly read, mandates appropriate payment to providers. *Cf. United States v. Testan*, U. S. Sup. Ct. No. 74-753, decided March 2, 1976.

[*Retroactive Corrective Adjustment*]

The standard of review set forth in *Goldstein, supra*, encompasses plaintiff's claim for money judgment, based as it is on an allegation that the BCA Medicare Provider Appeals Committee's decision violated the Medicare statute. Relying on 42 U. S. C. § 1395x(v)(1)(B) (1970), which states that the regulations "shall * * * provide for the making of suitable retroactive cor-

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bursement Disputes: An Analysis of the Administrative Hearing Procedures, 63 GEO. L. J. 107, 126-29 (1974). In *Salfi* the Supreme Court distinguished *Johnson v. Robison, supra*, a case in which the Court held that a statute similar to 42 U. S. C. § 405(h) did not preclude review of the question raised, in part on the ground that review of a constitutional challenge to the statute would have been cut off if the interpretation contended for by the Government in *Johnson* had prevailed, while no constitutional challenges would be denied review under the Social Security Act. See 422 U. S. at 762.

[8] For disputes over reimbursements with respect to fiscal periods ending on or after June 30, 1973, Congress has already resolved the problem of judicial review; only disputes where the amounts in controversy are less than $10,000 are left untreated by statute. See note 4 *supra*.

rective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive," plaintiff challenges the Committee's rejection of its attempt to use its work measurement study to prove that its Medicare reimbursements for 1967-1970 were inadequate. The Government's position is that it is immaterial that Whitecliff's work measurement study may show that its Medicare reimbursements for 1967-1970 were inadequate. The first leg of the argument is that, under Section 1395x(v)(1), the Secretary of Health, Education and Welfare is authorized to promulgate regulations setting forth the allowable methods for determining costs. The second leg is that the Secretary approved only two pertinent methods—the "departmental" and the "combination," 20 C. F. R. §§ 405.452(*a*), (*b*)[9]—but did authorize use of a "more sophisticated method" if the provider obtained prospective approval 20 C. F. R. § 405.453(d)(2)(ii). The third leg is that plaintiff admittedly used the "combination" method and did not seek or obtain advance approval for any other method.[10] It follows, according to the Government, that plaintiff is precluded from any further reimbursement even though it can show that, for its circumstances, the "combination" method led to inadequate reimbursement; the failure to ask for and obtain advance approval of some better method of determining costs is enough to bar the provider.

The answer, we think, is that the statute's retroactivity provision—quoted above—does not permit the Secretary to disregard the significant fact that his two approved methods of

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[9] These are methods for allocating or apportioning costs between Medicare patients and the provider's non-Medicare patients. Plaintiff's complaint is that the "combination" method it followed led in its case to inadequate allocation of costs to its Medicare patients. It is this difference for which Whitecliff is suing.

[10] See note 9 *supra*. Plaintiff's work measurement study did not utilize the "combination" or "departmental" methods.

cost-determination can lead to inadequate reimbursement in certain circumstances and in particular cases. That was the ruling in *Kingsbrook Jewish Medical Center v. Richardson*, 486 F. 2d 663 (2d Cir. 1973), in which the provider maintained, and the Government conceded, that the particular method there involved could result in inaccurate reimbursement in certain situations (including that plaintiff's). The Second Circuit held that the corrective adjustment mandated by 1395x(v)(1) applies wherever a cost method produces an inaccurate reimbursement and was "designed to rectify mistakes made by HEW in formulating a particular method of determining cost." 486 F. 2d at 669, 670. Obviously a regulation permitting a provider to seek a modified cost-method *for the future* is no substitute for the statutory requirement of "suitable retroactive corrective adjustments where for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."[11] The Secretary cannot excuse his agency or his agents (here, the BCA) from the statutory duty to make such retroactive adjustments by failing to promulgate the prescribed regulation or by using in its place regulations permitting only a prospective change of method and a retroactive adjustment to bring interim payments into agreement with the annual reimbursement produced by a

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[11] The Government contends that Section 1395x(v)(1) calls only for an annual adjustment, at year-end, when the total of the interim (monthly or more frequent) payments made under Section 1395g exceeds or falls below the reimbursement calculated on the basis of the cost report filed at year-end. The wording of the statute leaves no room for such an interpretation. It requires adjustment when the "reimbursement produced by the methods of determining costs" proves either inadequate or excessive. Under the regulations, the only reimbursement produced by the cost-determining methods is the reimbursement determined at the end of a fiscal period, after a provider has submitted its cost reports to which these methods are applied. The interim payments are merely monthly (or more frequent) estimates of costs, to which Section 1395x(v)(1) makes no reference. See 20 C. F. R. §§ 405.451-454; *Kingsbrook Jewish Center v. Richardson, supra*, 486 F. 2d at 669.

method of determining costs. See *Kingsbrook Jewish Medical Center v. Richardson, supra,* 486 F. 2d at 669-70.

The BCA Medicare Provider Appeals Committee therefore violated the Medicare statute when it insisted upon treating plaintiff's work measurement study as an unrecognized method of cost apportionment and found no support in the law or regulations for the requested retroactive adjustment, regardless of the accuracy of the work measurement study. The Committee should instead have determined whether Whitecliff had proved that its actual 1967-1970 Medicare costs (limited by reasonableness) exceeded the reimbursements it received under the "combination" method of determining costs and have granted a retroactive adjustment if Whitecliff had proved its claim that that method was inadequate for Whitecliff's situation. Because the Committee made no findings on Whitecliff's actual costs for 1967-1970, no comparison of those costs with its reimbursements for those years, and no evaluation of the accuracy of the method under which the provider was paid, we must remand to the Secretary for a hearing at which Whitecliff will be given an opportunity to prove its actual costs and the inadequacy of its reimbursement.[12]

We need not and do not decide plaintiff's remaining contention that the composition of the BCA Appeals Committee violated due process in that three of the five members were BCA employees. However, we note that one district court has found this issue to be substantial and another has ruled that the BCA Committee's composition does deprive a provider of the impartial decision-maker required by cases such as *Goldberg v. Kelly,* 397 U. S. 254, 271 (1970). See *Temple Univ. v. Associated Hosp. Serv.,* 361 F. Supp. 263, 267 (E. D. Pa. 1973); *St. Louis Univ. v. Blue Cross Hosp. Serv., Inc.,* 393 F. Supp.

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[12] 42 U. S. C. § 405(h) seems to us to indicate that federal courts do not have jurisdiction to try and determine in the first instance a provider's reasonable costs. See note 3 *supra.*

367, 371 (E. D. Mo. 1975); *Faith Hosp. Serv. v. Blue Cross Hosp. Serv., Inc.*, 393 F. Supp. 601, 602 (E. D. Mo. 1975).[13] See also *Homer & Platten, supra* note 7, at 131-33. But see *Community Hosp. of Indianapolis, Inc. v. Blue Cross Ass'n*, No. IP 73-C-615 (S. D. Ind. Dec. 18, 1974) (composition of Committee does not violate due process). The Secretary could obviate any due process challenge to the decision on remand by providing plaintiff with a hearing before a body not composed in its majority of BCA employees.

In conclusion, we hold that the plaintiff is entitled to a retroactive adjustment[14] in its reimbursement if it can prove that its actual reasonable costs for 1967-1970 exceeded its reimbursement on the "combination" method, but otherwise deny plaintiff's motion for summary judgment, deny the Government's cross-motion, and remand the case to the Secretary of Health, Education, and Welfare pursuant to Rule 149 and our remand statute, Pub. L. No. 92-415, 86 Stat. 652 (1972), 28 U. S. C. § 1491 (Supp. IV, 1974), for a hearing on plaintiff's reasonable costs and the adequacy of its reimbursements for the years 1967-1970, and for a retroactive corrective adjustment[15] if

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[13] In decisions issued after this opinion was prepared and adopted, the Eighth Circuit modified the Eastern District of Missouri's decisions in *St. Louis University* and *Faith Hospital*. The Circuit Court found, contrary to the district court, that the composition of the Committee is constitutionally permissible but agreed that due process precludes vesting the final determination of the issues in the Committee as constituted. Therefore, the court merely modified the district court's judgment, retaining the requirement that the Secretary make the final determinations. *St. Louis Univ. v. Blue Cross Hosp. Serv.*, Nos. 75-1274 & 75-1293 (8th Cir. Apr. 12, 1976); *Faith Hosp. Ass'n v. Blue Cross Hosp. Serv.*, Nos. 75-1301 & 75-1344 (8th Cir. Apr. 12, 1976).

[14] Subject to any valid regulation, applicable to this case, which may limit the amount of retroactivity of corrective adjustments under § 1395x(v)(1). See *Kingsbrook Jewish Medical Center v. Richardson, supra*, 486 F. 2d at 670.

[15] See note 14, *supra*.

plaintiff proves that its reimbursements were inadequate. Further proceedings in this court are stayed for a period of six (6) months from the date of this decision. Plaintiff's counsel is designated to advise the court by letter, at intervals of 90 days, of the status of the remand proceedings. The parties and the Secretary should also take note of Rule 150.